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Date Issued: December 29, 2000

Case No: 1998-BLA-791

In the Matter of

PAUL J. HUBBELL (DECEASED),

Claimant

v.

PEABODY COAL COMPANY,

Employer,

OLD REPUBLIC INSURANCE CO.,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:

Darlene Robinson, Esquire
For the claimant

Dana G. Meier, Esquire
For the employer/carrier

BEFORE: DONALD W. MOSSER
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis.

Surviving dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201 (1996).

By letter dated November 5, 1999, the claimant's attorney waived the scheduled hearing and agreed to submit to a decision on the record. The employer informally agreed to a decision on the record. Accordingly, by order dated May 4, 2000, Director's Exhibits 1 through 28, Claimant's Exhibits 1 through 4, and Employer's Exhibits 1 through 35 were admitted into evidence. The evidentiary record was closed, and the parties were permitted to file briefs.[1]

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to ALJX, DX, CX, and EX refer to the exhibits of the Administrative Law Judge, Director, claimant, and employer, respectively.

ISSUES

The following issues remain for resolution:

1. whether the evidence establishes a material change in conditions within the meaning of Section 725.309(d);

2. whether Mr. Hubbell has pneumoconiosis as defined by the Act and regulations;

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[1] By order dated May 4, 2000, Claimant's Exhibits (CX) 1 through 4 and Employer's Exhibits (EX) 36 through 54 were offered into evidence. As no objections have been received, these exhibits are hereby admitted.

3. whether his pneumoconiosis arose out of coal mine employment;

4. whether he is totally disabled; and,

5. whether his disability is due to pneumoconiosis.

(DX 28).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The claimant, Paul Hubbell, was born on September 18, 1919. Mr. Hubbell married Iris Turk on April 2, 1942. The miner died on December 8, 1999. The claimant had no children who were under eighteen or dependent upon him at the time his claim was filed. (DX 3, CX 8).

Mr. Hubbell filed his first application for black lung benefits on March 19, 1982. The Office of Workers' Compensation Programs ("OWCP") denied the claim on September 22, 1982. The miner did not request a hearing after this denial and did not submit any additional evidence. Therefore, his claim was closed. (DX 26).

The miner filed a second claim on December 3, 1984. This claim was denied by OWCP on March 12, 1985. Once again, the miner did not request a formal hearing and the claim was closed. (DX 27).

Mr. Hubbell filed his third claim on December 4, 1996. This claim was denied by OWCP on April 23, 1997. (DX 18). On June 23, 1997, Mr. Hubbell requested a formal hearing. (DX 19). An informal conference was held on Septmeber 25, 1997 and the district director made a recommendation on January 12, 1998 that the miner's claim remain denied. (DX 22). The miner rejected the district director's recommendations and requested a formal hearing on February 11, 1998. (DX 24). Pursuant to claimant's request for a formal hearing, the case was transferred to the Office of Administrative Law Judges for a formal hearing on April 24, 1998. (DX 28).

Coal Mine Employment

On his application for benefits, Mr. Hubbell alleged 18 years of employment in the coal mining industry. The parties agree that the claimant worked at least 18 years in the nation's coal mines. (DX 3, 22). Claimant last worked as a welder, machinist helper, and repair man. These jobs involved standing for 7 hours a day, climbing 250 feet into the air for

1 hour per day, and carrying 50 to 100 pounds for 100 feet 4 or 5 times per day. (DX 26).

Responsible Operator

Peabody Coal Company conceded it is the last employer in the coal mining industry for whom Mr. Hubbell worked for a cumulative total of at least one year and for one day after December 31, 1969. That company therefore is the properly designated responsible operator in this case. 20 C.F.R. §§ 725.492 and 725.493. (DX 22).

Duplicate Claim

In cases where a claimant files more than one claim and a prior claim has been finally denied, later claims must be denied on the grounds of the prior denial unless the evidence demonstrates "a material change in condition." 20 C.F.R. § 725.309 (d). The United States circuit courts of appeals have developed divergent standards to determine whether "a material change in conditions" has occurred. Because Paul Hubbell last worked as a coal miner in the state of Indiana, the law as interpreted by the United States Court of Appeals for the Seventh Circuit applies to this claim. *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989).

The Seventh Circuit has interpreted "material change in conditions" to mean "either that the miner did not have black lung disease at the time of the first application but has since contracted it and become totally disabled by it, or that his disease has progressed to the point of becoming totally disabling although it was not at the time of the first application." *Sahara Coal Co. v. Director, OWCP [McNew]*, 946 F.2d 554, 556 (7th Cir. 1991). Under this approach, "[i]t is not enough that the new application is supported by new evidence of disease or disability, because such evidence might merely show that the original denial was wrong". *Id.* Rather, claimant must establish that his condition has worsened since the denial of his previous claim. *Id.*

Claimant's prior claim for benefits was denied on March 12, 1985. Therefore, applying the *McNew* standard, I must review the evidence submitted subsequent to March 12, 1985 to determine whether claimant has proven a material change in his condition.

I. Medical Evidence

A. X-rays

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
10/30/86	DX 21	D. D. Peterson	Slight aortic sclerosis and

nonspecific
fibrosis

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
10/22/88	DX 21	J. W. Geurkink	Normal chest for age without change since 10/30/86
9/6/96	DX 21	B. A. Wendell	Mass-like density in left lingula; lungs demonstrate some basilar fibrosis and mild hyperinflation consistent with chronic obstructive pulmonary disease
9/23/96	DX 21	B. A. Wendell	Mass has not changed since 9/6/96 study; suggests a neoplastic mass
9/25/96	DX 21	B. A. Wendell	Approximate 10-20% left apical pneumothorax
9/27/96	DX 21	B. A. Wendell	Patient's pneumothorax appears to be resorbing
3/26/97	DX 21	B. A. Wendell	Status post left upper lobectomy with apparent scarring in the left chest
1/7/97 (2/14/97)	DX 11	A. Ahmed/Board certified radiologist and B-reader[2]	1/1; p/p

[2]When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). The Benefits Review Board and the Sixth Circuit Court of Appeals have approved attributing more weight to interpretations of "B" readers because of their expertise in x-ray classification. *See Warmus v. Pittsburgh & Midway Coal Mining Co.* 839 F.2d 257, 261, n.4 (6th Cir. 1988); *Meadows v. Westmoreland Coal Co.*, 6 BLR 1-773, 1-776 (1984).

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
1/7/97 (3/7/97)	DX 12	E. Sargent/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
1/7/97 (3/20/97)	DX 13	D. Gaziano/B-reader	0/1; t/q
1/7/97 (6/9/97)	DX 19	E. Cappiello/Board-certified radiologist and B-reader	2/2; p/q
1/7/97 (6/11/97)	DX 19	E. D. Aycoth/B-reader	1/1; p/p
1/7/97 (10/17/97)	EX 6	W. McGraw/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
1/7/97 (11/3/97)	EX 6	G. B. Goodman/B-reader	1/0; s/t
1/7/97 (12/4/97)	DX 22	E. Sargent/Board-certified radiologist and B-reader	No parenchymal or pleural abnormalities consistent with pneumoconiosis
10/14/97 (3/31/98)	EX 3	W. McGraw/Board-certified radiologist and B-reader	No radiographic evidence of pneumoconiosis
10/14/97 (4/16/98)	EX 4	G. B. Goodman/B-reader	1/0; s/s
10/14/97 (10/14/97)	EX 5	J. W. Selby/B-reader	No parenchymal or pleural abnormalities consistnent with pneumoconiosis
DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING

A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services. *See* 42 C.F.R. § 37.51(b)(2). Interpretations by a physician who is a "B" reader and is certified by the American Board of Radiology may be given greater evidentiary weight than an interpretation by any other reader. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984).

1/7/98	EX 11	B. A. Wendell	Right lung shows slight prominence of the markings and scattered calcified granulomas, but no acute process or effusion; no change since March 1997
4/27/98	EX 12	B. A. Wendell	Status post left partial pneumonectomy; overlying acute infiltrate at the left base is not excluded; an enlarged left hilar mass is not excluded
8/20/98	EX 11	B. A. Wendell	Status post partial left pneumonectomy with scarring changes and residual left hilar mass; No definite acute process
5/26/99 (5/27/99)	CX 1	D. Whitehead/Board-certified radiologist and B-reader	2/2; s/t
5/26/99 (9/8/99)	EX 40	W. McGraw/Board-certified radiologist and B-reader	When compared with standard ILO films, there is no evidence of pneumoconiosis
7/10/99	CX 6	J. J. Mathis	Evidence of prior left thoracotomy; no active infiltrates or consolidates demonstrated; a mass is identified adjacent to the left pulmonary hilum but appears unchanged from prior study

DATE OF X-RAY (REREADING)	EXHIBIT NO.	PHYSICIAN/ QUALIFICATIONS	READING
8/25/99	CX 6	M. M. Moss	No evidence of acute cardio-pulmonary disease

B. Pulmonary Function Studies

DATE	EXHIBIT	REPORTED HEIGHT[3]	AGE	FVC	FEV_1	MVV	TRACINGS	EFFORT
9/30/96	DX 9	67"	77	2.81	1.39	–	Yes	Not noted
1/7/97	DX 6	68"	77	3.01	1.69	80	Yes	Good
	[Results found acceptable on review by Drs. Long, Tuteur, and Renn. (DX 7; EX 9, 10).]							
10/14/97	EX 5	68"	78	3.69 (Pre-bronchodilator results)	1.99	59	Yes	Cooperative
				3.92 (Post-bronchodilator results)	1.99	68		
	[Results found acceptable on review by Dr. Renn. (ALJX 2; EX 1).] [All data except for MVV values are found to be valid by Dr. Tuteur. (ALJX 2; EX 2).]							
5/26/99	CX 1	67"	79	2.96 (Pre-bronchodilator results)	1.38	54.3	Yes	Poor initial effort
				3.34 (Post-bronchodilator results)	1.47	59.5		
	[Results found to be valid by Drs. Renn and Tuteur. (EX 38, 39).]							

C. Arterial Blood Gas Studies

DATE	EXHIBIT	pCO_2 (mm.Hg.)	pO_2 (mm.Hg.)	RESTING/ AFTER EXERCISE
1/7/97	DX 10	41.3	55.9	Resting
10/14/97	EX 5	41.0	52.0	Resting
		pCO_2	pO_2	RESTING/

[3]Because the physicians conducting the pulmonary function studies noted two different heights, two finding 67 inches and two finding 68 inches, I must make a finding on the miner's height. *See Protopappas v. Director, OWCP,* 6 BLR 1-221, 1-223 (1983). I find that the weight of the evidence proves Mr. Hubbell's height is at least 67 inches. (CX 1).

DATE	EXHIBIT	(mm.Hg.)	(mm.Hg.)	AFTER EXERCISE
4/27/98	EX 12	40.4	52.4	Resting
1/9/99	CX 4	34.9	55.2	Resting
8/17/99	CX 4	33.6	55.5	Resting
8/22/99	CX 4	34.5	51.7	Resting

D. Medical Reports

Dr. David Hormuth examined Mr. Hubbell on several occasions following his left upper lobectomy which was performed on October 9, 1996. Dr. Hormuth examined him on November 18, 1996, February 24, 1997, August 11, 1997, November 17, 1997, June 1, 1998, and October 26, 1998. He noted that the miner has been doing well after the surgery. At the August 11, 1997 examination, Dr. Hormuth noted Mr. Hubbell was currently on two liters of nasal cannula. He indicated that there is no evidence of supraclavi- cular adenopathy. Further, Dr. Hormuth stated that Mr. Hubbell's chest x-rays demonstrate marked improvement in the atelectasis that he had on a previous evaluation. As of the October 26, 1998 examination, the physician stated Mr. Hubbell's chest x-rays show no significant change except some scarring in the left lung base. (DX 9; EX 13-16, 28).

The miner was examined by Dr. Reynaldo Carandang on January 7, 1997. The physician performed a chest x-ray, a pulmonary function study, and an arterial blood gas study. Dr. Carandang also noted that Mr. Hubbell had 18 and one-half years of coal mine employment, performing work mainly at the tipple. He also noted that although Mr. Hubbell had quit smoking by the date of the examination, the miner had a history of smoking cigarettes for 25 years at the rate of one pack per day. The physician diagnosed Mr. Hubbell with chronic obstructive pulmonary disease, lung cancer, and hypertensive cardiovascular disease. Dr. Carandang opined that Mr. Hubbell's chronic obstructive pulmonary disease was due to air pollutants, his lung cancer was caused by cigarette smoking, and Mr. Hubbell's hypertensive cardiovascular disease was caused by hypertension. He stated that Mr. Hubbell had a moderate to severe impairment. Further, Dr. Carandang indicated that chronic obstructive pulmonary disease and lung cancer both contribute equally to his impairment. Dr. Carandang did not specifically indicate whether Mr. Hubbell had the ability to perform his last coal mine job, but he did indicate that Mr. Hubbell was unable to do exertion. (DX 8).

On April 22, 1997, Dr. Sarah Long provided a medical opinion regarding whether Mr. Hubbell suffered from pneumoconiosis. She indicated that she does not believe the miner had pneumoconiosis based upon a review of the x-ray interpretations by B-readers which are negative for pneumoconiosis. Further, she stated the physical examination reveals that Mr. Hubbell had a lobectomy for lung cancer and that he had findings of chronic obstructive pulmonary disease. (DX 14).

Dr. Tuteur reviewed Mr. Hubbell's January 7, 1997 pulmonary function study and issued a report on September 30, 1997. The physician concluded that the study showed a moderate obstructive ventilatory defect without a restrictive component. (EX 9). Dr. Tuteur also reviewed the miner's October 14, 1997 pulmonary function study and indicated that the data represented no worse than a minimal obstructive ventilatory defect not significantly changed following the administering of a bronchodilator and not associated with a restrictive ventilatory defect. The physician reviewed Mr. Hubbell's May 26, 1999 pulmonary function study and concluded that the test showed a severe obstructive ventilatory defect that does not improve significantly following the administration of a bronchodilator. (ALJX 2; EX 2, 30, 38).

Dr. Joseph Renn, a Board-certified internist with a sub-specialty in pulmonary disease, reviewed Mr. Hubbell's January 7, 1997 pulmonary function study and issued a report on October 1, 1997. He opined that the miner showed a moderate obstruction. Further, he stated that the MVV and the diffusing capacity are invalid. (EX 10). Dr. Renn also reviewed the miner's October 14, 1997 pulmonary function study and opined that the ventilatory function represented a mild obstruction. Further, he stated that the MVV and the diffusing capacity are invalid. Upon review of Mr. Hubbell's May 26, 1999 pulmonary function study, Dr. Renn noted that the study represented a severe, significantly bronchoreversible obstruction. (ALJX 2; EX 1, 31, 39).

Dr. Jeff W. Selby, a Board-certified internist with subspecialties in pulmonology and critical care, examined Mr. Hubbell on October 14, 1997. The physician noted a smoking history of 26 pack years. He opined that the miner did not have coal workers' pneumoconiosis and that he was not totally disabled from a respiratory standpoint as it relates to his previous coal mine employment. Dr. Selby noted the miner did have a severe respiratory abnormality associated with a severe diffusion process and some interstitial changes on chest x-ray that suggest interstitial lung disease, other than pneumoconiosis. The physician noted that Mr. Hubbell has a significant impairment which is a moderate, almost severe,

obstructive defect from the miner's years of smoking. Dr. Selby indicated that the miner likely has emphysema. Further, the physician opined that Mr. Hubbell has a form of interstitial lung disease of an autoimmune or similar origin that usually causes severe gas abnormalities, much more than coal workers' pneumoconiosis would with the miner's chest x-ray presentation. (EX 5, 53).

The record contains records from Greene County General Hospital. On February 16, 1998, Dr. Russell Dukes examined the miner. Dr. Dukes noted a smoking history of one pack per day for 25 years, but that the miner quit in 1964. He noted that Mr. Hubbell worked in the coal mines for years and years, but did not specify a specific number of years. Dr. Dukes diagnosed the miner with severe chronic obstructive pulmonary disease and stated that he is oxygen dependent. Further, he noted Mr. Hubbell was status post left upper lobectomy, that he had a history of duodenal ulcer, and he was status post appendectomy and heniorrhaphy. (EX 11).

Mr. Hubbell was admitted again to Greene County General Hospital on April 28, 1998 and was discharged on April 30, 1998. Upon admittance, the miner was diagnosed by Dr. Paul Esguerra, Jr. with left lower lobe pneumonia, acute sinusitis, chronic obstructive pulmonary disease, chronic essential hypertension and status post left upper lobectomy for prior malignancy. Dr. Esguerra noted that Mr. Hubbell smoked for 20 pack years and that he had 18 and a half years of coal mine employment. Upon discharge, the miner was given final diagnoses of left basilar pneumonia, acute sinusitis, chronic obstructive pulmonary disease, chronic essential hypertension, and status post left upper lobectomy for prior malignancy. (EX 12).

On December 6, 1999, Mr. Hubbell was again admitted to the Greene County General Hospital. The miner was admitted for a syncopal episode and a pelvis fracture. Dr. Eric Wilson, the attending physician, listed several final diagnoses in Mr. Hubbell's discharge summary including new onset pelvis fractures, peptic ulcer disease, gastroesophageal reflux disease, pneumoconiosis, chronic obstructive pulmonary disease, right heart failure, tricuspid insufficiency, tobacco abuse, hypoxemia, hypertension, status post lung cancer in 1986 with upper lobe resection, history of rectal bleeding (due to diverticulosis), hypothyroidism, and pulmonary hypertension. (CX 7; EX 11, 12).

Dr. Peter Tuteur, who is Board-certified in internal medicine and pulmonary disease, reviewed the medical evidence of record and issued a consultative report on April 16, 1999. Dr. Tuteur noted a smoking history of 20 to 25 years at the rate of one to two packages per day ending in 1964. Further,

he stated that the miner had 18 years of coal mine employment. Dr. Tuteur opined that there is no convincing information to support a diagnosis of coal workers' pneumoconiosis. In addition, he indicated that Mr. Hubbell has chronic obstructive pulmonary disease, but that this condition is not related to, not aggravated by, or caused by either the inhalation of coal mine dust or the development of coal workers' pneumoconiosis. Dr. Tuteur explained that when coal workers' pneumoconiosis is sufficiently advanced to produce abnormalities on chest examination, one expects to find the presence of inspiratory crackling sounds. However, this was not heard upon Mr. Hubbell's examinations. The physician opined that it is with reasonable medical certainty that the most significant problem affecting Mr. Hubbell's health status is squamous cell carcinoma of the lung, the left upper lobe lobectomy and its sequelae. Dr. Tuteur indicated that neither the carcinoma nor the development of sequelae of the treatment are in any way related to, aggravated by, or caused by the inhalation of coal mine dust or the development of coal workers' pneumoconiosis. The physician stated that none of Mr. Hubbell's health problems is in any way related to coal dust exposure. Dr. Tuteur opined that the miner is substantially limited in his physical activity, but that this limitation is not related to the inhalation of coal mine dust or coal workers' pneumoconiosis. He stated that pulmonary embolism with pulmonary vascular obstruction is most likely the specific cause, but that process is also not related to, aggravated by, or caused by the inhalation of coal mine dust or coal workers' pneumoconiosis. (EX 35, 43).

Dr. William Houser, a Board-certified internist with subspecialties in pulmonary disease and critical care medicine, examined the miner on May 26, 1999. He also performed a chest x-ray and a pulmonary function study. Dr. Houser noted that Mr. Hubbell had 18 and a half years of coal mine employment, all on the surface. The physician did not note a smoking history. Dr. Houser diagnosed the miner with coal workers' pneumoconiosis, category 2/2, chronic obstructive pulmonary disease, emphysema, chronic bronchitis, as well as other diseases unrelated to his pulmonary condition. The physician opined that based upon the miner's occupational exposure and chest x-ray findings, Mr. Hubbell has coal workers' pneumoconiosis, category 2/2. Further, he contends that the pulmonary function studies show a moderately severe airway obstruction. Dr. Houser contended that the miner is permanently and totally disabled from a respiratory standpoint and that coal workers' pneumoconiosis is a significant contributing factor to that disability. In addition, the physician stated that in his opinion, the miner's cigarette smoking, as well as his exposure to rock and coal dust, are contributing factors in causing Mr. Hubbell's

chronic bronchitis, emphysema, and moderately severe chronic obstructive pulmonary disease. (CX 1).

Dr. Houser also reviewed a pathology report from specimens which were taken from Mr. Hubbell's cancer surgery for resection of the left upper lobe on October 9, 1996. Upon review of the report, Dr. Houser stated that in the lung parenchyma, areas of anthracotic pigment are noted, as well as emphysema. He further indicated that the lymph node also shows prominent anthracotic deposition. Dr. Houser opined that the findings are consistent with and support a clinical diagnosis of coal workers' pneumoconiosis. (CX 4).

Dr. Raphael Caffrey, a Board-certified pathologist, reviewed the medical evidence of record, including nine surgical pathology slides labeled "S96-13429" which were taken from the left upper lobectomy specimen on Mr. Hubbell, along with adjacent lymph nodes. Dr. Caffrey issued a consultative report on November 6, 1999. He listed final diagnoses of poorly differentiated squamous cell carcinoma of the lung with marked desmoplastic reaction and chronic inflammation, no evidence of metastasis to adjacent lymph nodes, mild chronic bronchitis, centrilobular emphysema, mild amount of anthracotic pigment within lung tissue, mild to moderate amount of anthracotic pigment in lymph nodes and probable interstitial lung disease (ILD). Dr. Caffrey opined that he could not diagnose Mr. Hubbell with coal workers' pneumoconiosis based upon the evidence that he reviewed. Further, he stated that although he did identify some anthracotic pigment, it is not synonymous with the disease of coal workers' pneumoconiosis. Dr. Caffrey stated that although Mr. Hubbell does have significant pulmonary pathology, none of it is attributable to his coal mine employment. Rather, he contended that Mr. Hubbell's chronic bronchitis, emphysema, and carcinoma of the lung are all caused by years of cigarette smoking. The physician opined that the miner does have interstitial lung disease. Dr. Caffrey noted that the fact that Mr. Hubbell was a coal miner did not cause or contribute to the pulmonary disease which he suffers, nor did his employment cause his pulmonary disability. (EX 42).

E. Medical Records

The record contains progress notes from Dr. Antonio-Miranda. The majority of these records are illegible, however, it appears that the physician diagnosed the miner with various disorders including chronic obstructive pulmonary disease and HPN. (EX 8).

Mr. Hubbell underwent a ventilation and perfusion scan on October 8, 1996. The scan was interpreted by Drs. Pete Stangas and Larry Heck. The physicians indicated that the findings from the scan are consistent with chronic obstructive pulmonary disease. Further, the doctors note that a chest radiograph performed before the scan shows a lung mass in the left lower lobe. They noted the rest of the lung fields appear clear of active disease. (EX 17).

The miner was admitted to the Methodist Hospital of Indiana on October 9, 1996 and was discharged on October 16, 1996. Mr. Hubbell underwent a fiberoptic bronchoscopy and a left upper lobectomy on October 9, 1996. The miner was preoperatively diagnosed with lung cancer and was diagnosed with the same postoperatively. Upon gross and microscopic examination, Dr. Jose Bonnin, a pathologist, opined that the findings are compatible with primary carcinoma and he classified the tumor as a poorly differentiated squamous cell carcinoma in the lung.

The record contains chest x-rays from the Methodist Hospital taken of Mr. Hubbell from October 11, 1996 through October 26, 1998. These x-rays were not taken for the purpose of diagnosing pneumoconiosis and are all related to Mr. Hubbell's lung cancer. None of the x-ray interpretations mentions pneumoconiosis or any coal dust related disease. (DX 9; EX 19-27, 29).

The record contains reports from the Medical Center of Vincennes Wabash Valley Coal Miners Respiratory Clinic dated from January 31, 1998 through July 20, 2000. These records contain Dr. Carandang's progress notes. These records contain diagnoses of coal workers' pneumoconiosis, chronic obstructive pulmonary disease, lung cancer and gasteroesphophageal reflux disease (GERD). (CX 5).

Various other records from Good Samaritan Hospital dated from March 1998 through August 1999 are included in the record. These records include a cytopathology report of the miner's sputum and various general chemistry reports. In addition, there are chest x-rays which have been performed, but were not read for the purpose of diagnosing pneumoconiosis. These x-rays were performed for various reasons, such as flu, headache, nausea, pneumonia, and dyspnea. Mr. Hubbell was admitted to Good Samaritan hospital in January, July, and August 1999. During this time period, the miner was diagnosed with acute exacerbation of chronic obstructive pulmonary disease, acute bronchitis, hypertension, coal workers' pneumoconiosis, gastroesophageal reflux disease, history of lung cancer status post lobectomy, acute

pneumonitis with hypoxemia, hypertension, and sinusitis. (CX 5, 6).

Mr. Hubbell died on December 8, 1999. Dr. Wilson signed the miner's death certificate. The cause of death was listed as asystole, right ventricular failure, and chronic obstructive pulmonary disease. (CX 8).

F. CT Scans

A CT scan of Mr. Hubbell's chest was performed on September 25, 1996. Dr. B. A. Wendell interpreted the results. The scan identified a lobulated, fairly homogenoeus pleural based mass in the left lingula. No appreciable calcificiation was noted. The physician noted a probable neoplastic mass in the left lingula. (DX 21).

On January 11, 1999, another CT scan of the chest with contrast was performed. Dr. Dennis King interpreted this scan and opined that there is evidence of a prior left lobectomy and there are extensive emphysematous changes throughout both lungs with some mild fibrosis. He noted that some scarring is seen within the left lung. (CX 5).

Mr. Hubbell underwent a CT scan of his chest on September 15, 1999. The reason for the procedure was chronic obstructive pulmonary disease, RHF, and pneumoconiosis. Dr. B. A. Wendell interpreted the scan and concluded that the scan showed severe chronic obstructive pulmonary disease, no definite acute process. (EX 48).

G. Biopsy Evidence

A flouroscopically guided needle biopsy was performed of the left lingular mass on September 25, 1996. Malignant material was confirmed by the pathologist. There was a small post procedure pneumothorax noted. (DX 21).

On September 25, 1996, Dr. Wendell performed a fine needle aspiration of the left lower lung. This procedure was evaluated by a pathologist during the procedure. Dr. P. M. Canfield issued a report and indicated that the findings are suggestive of large cell poorly differentiated carcinoma. (DX 21).

Dr. Tony Zerbe received eight slides labeled FNA96-130 on Mr. Hubbell on October 8, 1996. Dr. Zerbe listed a final diagnosis that malignant cells are present and that cytomorph-plogic features are consistent with a non-small cell carcinoma. (EX 18).

On October 11, 1996, Dr. Jose Bonnin prepared an addendum to Mr. Hubbell's pathology report. He summarized that the pathologists classify the tumor as a poorly differentiated squamous cell carcinoma in the lung. Further, the physician noted the presence of prominent anthracotic pigment deposits on the lymph node. (CX 4; EX 41).

II. Discussion

Because Mr. Hubbell filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish a material change in condition, claimant must establish either that the miner did not have black lung disease at the time of the first application but has since contracted it and become totally disabled by it, or that the disease has progressed to the point of becoming totally disabling although it was not at the time of the first application. *See Sahara Coal Co. v. Director, OWCP [McNew]*, 946 F.2d 554, 556 (7th Cir. 1991).

The Act defines "pneumoconiosis" as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis.

Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. The record contains twenty five interpretations of fourteen chest x-rays that were conducted in connection with Mr. Hubbell's current claim. Of these interpretations, seven are negative for pneumoconiosis, six are positive, and twelve of the interpretations are silent as to the existence of pneumoconiosis. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (*en banc*); *Stanford v. Director, OWCP*, 7 BLR 1-541 (1984). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP,* 12 BLR 1-6 (1988); *Clark, supra*.

The January 7, 1997 x-ray was interpreted as positive by two dually-qualified physicians and negative by two dually-qualified physicians. However, two B-readers read the same x-ray as positive, while one B-reader read the x-ray as negative. I find this x-ray weighs in favor of a finding of pneumoconiosis due to the fact that more B-readers interpreted this x-ray as positive.

The October 14, 1997 x-ray was read as negative by Dr. McGraw, a dually-qualified physician and positive by Dr. Goodman, a B-reader. I give greater weight to Dr. McGraw's interpretation of this x-ray due to his superior qualifications.

Finally, the May 26, 1999 x-ray was read a positive by Dr. Whitehead and negative by Dr. McGraw, both of whom are dually-qualified. Where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence. *Greenwich Collieries v. Director, OWCP*, 114 S. Ct. 2251 (1994). I find that Drs. Whitehead and McGraw's opinions regarding the May 26, 1999 x-ray are in equipoise and therefore, the claimant has failed to meet his burden of proof.

I conclude that the weight of the x-ray evidence relating to Mr. Hubbell's 1996 claim does not weigh in favor of a finding of pneumoconiosis. Moreover, the more recent x-rays are not sufficient to prove the existence of the disease. Thus, I find pneumoconiosis is not established under Section 718.202(a)(1).

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. Mr. Hubbell had a flouroscopically guided needle biopsy of the left lingular mass in his left lung on September 25, 1996. He further underwent a fine needle aspiration of his left lower lung. (DX 21). The results of these tests indicated the presence of large cell poorly differentiated carcinoma and found that malignant cells were present. Although Dr. Bonnin did find the presence of anthracotic pigment in Mr. Hubbell's lung tissue and on his lymph node, no specific finding of anthracosis or pneumoconiosis was made.

Dr. Caffrey, a highly qualified physician, reviewed the pathology slides and stated the miner did not have pneumoconiosis. I give greater weight to Dr. Caffrey's opinion because of his superior qualifications. Dr. Bonnin's qualifications are not contained in the record. Accordingly, the miner has not established the existence of pneumoconiosis through biopsy evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply

to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides a claimant also may establish the existence of pneumoconiosis if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Since the prior denial, the record contains reports from seven physicians who examined Mr. Hubbell and reports from two physicians who reviewed the medical evidence of record. (CX 7; EX 11-16, 28, 35, 42-43; DX 8, 9, 14). Of these physicians, only Drs. Houser and Wilson opined that Mr. Hubbell had pneumoconiosis.

Dr. Wilson was the attending physician when the miner was admitted to Greene County General Hospital on December 6, 1999. (CX 7). However, Dr. Wilson's qualifications are not contained in the record. I find that Dr. Wilson's diagnosis of pneumoconiosis is not well-reasoned or well-documented and, therefore, give it less weight. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(*en banc*). Dr. Wilson provides no explanation as to how he arrived at the conclusion that the miner had pneumoconiosis. Mr. Hubbell was admitted to the hospital for new pelvic fractures, injuries that were totally unrelated to pneumoconiosis.

I also give less weight to Dr. Houser's opinion, despite his qualifications. Dr. Houser opined that Mr. Hubbell had pneumoconiosis based upon chest x-ray findings and occupational exposure. However, the physician did not note the miner's smoking history. Moreover, the only objective test results on which he relied is the x-ray. I therefore find it does not meet the requirements of Section 718.202(a)(4).

Drs. Dukes, Esguerra, and Carandang all diagnosed the miner with chronic obstructive pulmonary disease. However, Dr. Carandang opined that Mr. Hubbell's chronic obstructive pulmonary disease was due to air pollutants. Drs. Dukes and Esguerra both examined the miner while he was hospitalized. None of the physicians related the miner's chronic obstructive pulmonary disease to his coal mine employment. Thus, the diagnoses do not fit within the statutory definition of pneumoconiosis. 20 C.F.R. § 718.201.

Dr. Antonio-Miranda diagnosed Mr. Hubbell with chronic obstructive pulmonary disease, but did not provide an opinion as to whether the chronic obstructive pulmonary disease is in any way related to the miner's coal mine employment. Dr. Hormuth made no mention of pneumoconiosis or any chronic

pulmonary disease arising out of coal mine employment which would meet the definition of pneumoconiosis provided in Section 718.201. The opinions of Drs. Dukes, Esguerra, Carandang, and Antonio-Miranda are silent as to the existence of pneumoconiosis. I find that none of the opinions is probative to the issue of the existence of one and therefore, give them less weight.

I give greater weight to the opinions of Drs. Tuteur, Selby, and Caffrey due to their heightened credentials. All of these physicians' opinions are well-reasoned and well-documented. A reasoned opinion is one which contains underlying documentation adequate to support the physicians' conclusions. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observation, facts, and other data on which he bases his diagnosis. *Aegir v. Director, OWCP*, 7 BLR 1-860 (1985). All of these physicians state the data and findings upon which they relied in making their diagnoses. Further, Dr. Caffrey reviewed the pathology slides in addition to the entire medical record. I give his opinion great weight due to the fact that his opinion is supported by more extensive documentation than the remaining physicians' opinions. *See Sabett v. Director, OWCP*, 7 BLR 1-229 (1984).

Neither of the two physicians who interpreted Mr. Hubbell's CT scans mentioned the existence of pneumoconiosis or any coal-dust related condition. Therefore, I also find that the CT scans do not weigh in favor of a finding of pneumoconiosis. The opinions of Drs. King and Wendell are silent as to the existence of pneumoconiosis and, therefore, I find that their opinions are not probative to the issue. Thus, I find that Mr. Hubbell has not established the existence of pneumoconiosis pursuant to Section 718.202(a)(4).

As the evidence does not establish the existence of pneumoconiosis, this claim cannot succeed. Regardless, even if the evidence has established this element, it fails to prove another requisite element of entitlement, that claimant's totally disabling respiratory impairment is due to pneumoconiosis.

I find that the evidence establishes Mr. Hubbell was totally disabled from a respiratory standpoint at the time of his death. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(2). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability.

See Beatty v. Danri Corp., 16 BLR 1-11, 1-15 (1991). Section 718.204(c) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(c)(1) and (c)(2), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies.[4] Since the prior denial, four pulmonary function studies were performed, one of which is qualifying. I give the greatest weight to the qualifying study performed on May 26, 1999 based on the fact that this study is the most recent study of record. *Coleman v. Ramey Coal Co.*, 18 BLR 1-9 (1993). Further, I give this study great weight based on the fact that it was validated by Drs. Renn and Tuteur. Therefore, I find that the pulmonary function study evidence supports a finding of a totally disabling respiratory impairment under Section 718.204(c)(1).

Six arterial blood gas studies were also performed since the prior denial, all of which produced qualifying values. Thus, I find that the claimant has established that he had a totally disabling respiratory impairment under Section 718.204(c)(2).

Section 718.204(c)(3) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Where a claimant cannot establish total disability under subparagraphs (c)(1), (c)(2), or (c)(3), Section 718.204(c)(4) provides that total disability is established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work.

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[4]A "qualifying" pulmonary function study or arterial blood gas study yields values which are equal to or less than the applicable table values, *i.e.*, Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(c)(1) and (c)(2). A "non-qualifying" test produces results which exceed the requisite table values.

While none of the physicians specifically state whether Mr. Hubbell could have engaged in his usual coal mine employment or comparable and gainful work, all of the physicians recognize that the miner was limited in his physical activity. Drs. Hormuth, Antonio-Miranda, and Long do not provide an opinion as to whether the miner had a totally disabling respiratory impairment. Dr. Houser opined that Mr. Hubbell was permanently and totally disabled from a respiratory standpoint. Dr. Renn reviewed the miner's pulmonary function studies and noted from a mild to severe obstruction, the severity of which increased with the later pulmonary function studies. Dr. Selby indicated the miner had a moderate, almost severe obstructive defect. Dr. Caffrey stated Mr. Hubbell had significant pulmonary pathology. Dr. Tuteur opined the miner was significantly limited in his physical activity. Dr. Carandang also noted that he had a moderate to severe impairment and would have been unable to exert himself.

Mr. Hubbell's previous jobs were as a welder, machinist helper, and repairman which required him to stand for 7 hours per day, climb 250 feet up into the air for 1 hour per day, and to lift and carry 50 to 100 pounds for over 100 feet 4 to 5 times per day. I therefore find that the reasoned medical opinions support that Mr. Hubbell had a totally disabling respiratory impairment at the time of his death under Section 718.204(c), because they support the conclusion that Mr. Hubbell was unable to perform his previous arduous work as a coal miner.

I should finally note that the pulmonary function and arterial blood gas study evidence and the medical opinion evidence must be weighed together. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). Because I have found that the pulmonary function and arterial blood gas evidence and the medical evidence all weigh in favor of a finding of total disability, I find the weight of the medical evidence proves that Mr. Hubbell has established that he had a totally disabling respiratory impairment under Section 718.204(c).

Finally, claimant must also establish that his total disability is due to pneumoconiosis. 20 C.F.R. § 718.204(b). To satisfy this requirement, the United States Court of Appeals for the Seventh Circuit requires a claimant to prove that his pneumoconiosis is a "contributing cause" of his total disability. *Compton v. Inland Steel Coal Co.*, 933 F.2d 477, 480 (7th Cir. 1991). Under this standard, a claimant's pneumoconiosis "must be a necessary, but need not be a sufficient condition of the miner's total disability." *Id. See also Shelton v. Director, OWCP*, 899 F.2d 690, 693 (7th Cir. 1990).

While all of the physicians agree that Mr. Hubbell was totally disabled from a respiratory standpoint, they disagree regarding the causation of total disability. Dr. Houser opined that coal workers' pneumoconiosis was a significant contributing cause of Mr. Hubbell's total disability. Further, he indicated that smoking was also a contributing factor and that the miner's exposure to rock and coal dust contributed to Mr. Hubbell's chronic bronchitis, emphysema and moderately severe chronic obstructive pulmonary disease.

All of the other physicians' opinions are either silent as to causation of total disability or indicate that pneumoconiosis was not a contributing cause of the miner's totally disabling respiratory impairment. The opinions of Drs. Hormuth, Antonio-Miranda, Long, Dukes, and Esguerra are all silent as to the causation of disability. Dr. Carandang opined that the miner's total disability was caused by chronic obstructive pulmonary disease and lung cancer. However, he does not indicate that the miner's chronic obstructive pulmonary disease was related to the miner's employment.

Dr. Selby stated that Mr. Hubbell's disability was due to cigarette smoking. Dr. Tuteur indicated that the miner's disability was caused by pulmonary embolism with pulmonary vascular obstruction and that pneumoconiosis did not contribute to the miner's disability. Dr. Caffrey stated Mr. Hubbell's disability was caused by chronic bronchitis, emphysema, and carcinoma of the lung which are all caused by cigarette smoking. Dr. Caffrey noted that the miner's coal mine employment did not contribute to his disability.

I give less weight to Dr. Houser's opinion regarding causation of total disability due to the fact that he failed to document any smoking history when reaching his conclusions. Further, Drs. Houser, Selby, Tuteur, and Caffrey are all highly qualified physicians. The opinions of Drs. Carandang, Selby, Tuteur, and Caffrey are all well-reasoned and well-documented and are consistent with my determination that the miner failed to establish the existence of pneumoconiosis. I find that the claimant has failed to meet his burden of proof for this element. Thus, under the *McNew* standard, the evidence fails to prove Mr. Hubbell's condition had materially changed since the March 15, 1998 denial of his previous claim. Since the evidence fails to prove Mr. Hubbell's condition had materially changed from the March 15, 1985 denial, the claim filed December 4, 1996 must be denied under Section 725.309(d). Accordingly, benefits must be denied.

Attorney's Fee

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any attorney's fee to the claimant for legal services rendered in pursuit of benefits.

ORDER

The claim of Paul J. Hubbell (Deceased) for benefits under the Act is denied.

DONALD W. MOSSER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Workers' Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601. See 20 C.F.R. §§ 725.478 and 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.